

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN190S</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/10/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>RENOWN SKILLED NURSING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1835 ODDIE BLVD</b> <b>SPARKS, NV 89431</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>Surveyor: 23119 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 8/6/09 and finalized on 9/9/09, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Complaint #NV00022120 was unsubstantiated with an unrelated deficiency cited. (See Tag Z 230).</p> <p>Complaint #NV00022666 was unsubstantiated with an unrelated deficiency cited. (See Tag Z 230).</p> <p>Complaint #NV00021562 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	Z 000		
Z230 SS=D	<p>NAC 449.74469 Standards of Care</p> <p>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and</p>	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z230	<p>Continued From page 1</p> <p>psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439.</p> <p>This Regulation is not met as evidenced by: Surveyor: 23119 Based on record review and interview the facility failed to hold blood pressure medication in accordance with physician order for 1 of 6 residents (#5) and failed to promptly obtain a speech therapy evaluation on 2/20/09 for 1 of 6 residents (Resident #2).</p> <p>Severity 2 Scope 1</p>	Z230			

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